VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Newcomer Health Program
Supplemental Data Collection Form

Place Patient **ENCOUNTER** Label Here:

Name:_____

DOB:_____ Pt #:_____

Encounter #:_____

Alien ID#: _____

Date of Arrival in US: _____

VOLAG: _____

Health District: _____

Did the patient receive an initial health screening? ☐Yes ☐No **DATE OF INITIAL ASSESSMENT**:_____/_____/_____

If the patient did not receive a screening, why not? ☐Moved ☐Refused ☐Never located ☐Missed multiple appts. ☐ Unknown ☐Other_____

Assessment Findings: Is the patient: ☐Male ☐Female

Was the dental evaluation WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the hearing evaluation WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the vision evaluation WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No
Were nutritional abnormalities found?		☐Yes	☐No	Referral needed?	☐Yes ☐No
For children, was the developmental assessment WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No ☐N/A
If female, was the pregnancy test:	☐Not Done	☐Pos	☐Neg.	Referral needed?	☐Yes ☐No

Was the patient referred for follow up on any of the following? (Check all that apply.)

☐Diabetes	☐HTN	☐Mental Health	☐Suicidal Thoughts	☐Neurology
☐GI Issues	☐Orthopedics	☐OBGYN	☐Infectious Disease	☐HIV
☐Elevated Cholesterol		☐Disability Services	☐Other (specify)_____	

Was the client referred/linked to a Primary Care Provider? ☐Yes ☐No

Laboratory Findings:

Was the CBC WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the metabolic panel WNL?		☐Yes	☐No	Referral needed?	☐Yes ☐No
Were the Hepatitis B Results WNL?	☐Not Done	☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the HIV result WNL?	☐Not Done	☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the RPR result WNL?	☐Not Done	☐Yes	☐No	Referral needed?	☐Yes ☐No
Was the Urinalysis WNL?	☐Not Done	☐Yes	☐No	Referral needed?	☐Yes ☐No
If tested, were the Hepatitis C results WNL?	☐Not Done	☐Yes	☐No	Referral needed?	☐Yes ☐No

Tuberculosis Screening:

Test for TB infection (TST or IGRA)		☐Pos	☐Neg.	☐Not Done	
If the patient was referred for a chest x-ray was it WNL?		☐Yes	☐No	☐Not Done	
Was treatment recommended for:	**Active TB Disease?**	☐Yes	☐No	**LTBI?**	☐Yes ☐No

Person Completing Form:_____ **Phone #**:(____)_____

Print Name (Last Name, First Name)

Forms **MUST** be returned within 30 days of assessment in order for the LHD to receive reimbursement.
Please **FAX** completed forms to the Newcomer Health Program at (804)864-7913

Revised 2/1/2013